LabGenomics

GYN & SEXUAL HEALTH REQUISITION

CLIA ID # 31D2026917

PATIENT INFORMATION *(REQUIRED)*

Date of Collection: _____ Time of Collection: _____

Cell #: _____ Email: _____

Home #: _____ Street Address: _____

Apt: _____ City: _____ State: _____ Zip: _____

DOB (MM/DD/YYYY): _____ / _____ / _____ SSN #: _____

(SSN # required for uninsured patients only)

Gender Identity and Sexual Orientation

- ☐ Male
- ☐ Female
- ☐ Non-Binary/Genderqueer
- ☐ Transgender Male
- ☐ Transgender Female
- ☐ Choose not to disclose
- ☐ Straight or Heterosexual
- ☐ Lesbian, Gay or Homosexual
- ☐ Bisexual
- ☐ Other: _____

Race and Ethnicity — Select all that apply

- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Asian
- ☐ White
- ☐ Choose not to disclose
- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino
- ☐ Other: _____

Guidelines for patient demographics are provided by NJDOH/CLIS (NJSA 45:9-42.46 to -42.49)

REFERRING PHYSICIAN INFORMATION *(REQUIRED)*

INSURANCE INFORMATION *(REQUIRED)*

Policyholder Name: _____

Insurance Name: _____

Policy #: _____

Group #: _____

Please provide a copy of the front & back of insurance card(s).

- ☐ Bill Insurance
- ☐ Bill Client
- ☐ Self Pay

SPECIMEN ID: T128353 **LAB ACCESSION #:** _____

CLINICAL HISTORY

Menstrual Status

Date of LMP: _____

- ☐ Pregnant ☐ Postpartum
- ☐ Menopausal _____ years
- ☐ Prior PAP Result & Date: _____
- ☐ Prior Biopsy & Date: _____

Relevant History

- ☐ Routine Screening
- ☐ Bleeding
- ☐ Hormone Therapy
- ☐ Post Hysterectomy
- ☐ Radiation
- ☐ Other: _____

PROCEDURE & SPECIMEN SOURCE

Cervix	☐ Biopsy	☐ Polypectomy	☐ LEEP	☐ Swab
Endocervical	☐ Curettage			
Endometrial	☐ Biopsy	☐ Polypectomy	☐ Curettage	
Vulva	☐ Biopsy	☐ Swab		
Vaginal	☐ Biopsy	☐ Swab		
Anorectal	☐ Swab			
Throat	☐ Swab		Other: _____	
Urine	☐ Sterile Cup			

ICD-10 CODES *(REQUIRED FOR TESTING)*

GYN

***UTI - Must check off 1 code. Test will not processed without properly marked Statement of Medical Necessity.**

☐ Z01.419	Routine GYN exam	☐ N30.00	Acute cystitis without hematuria
☐ Z01.411	GYN exam with abnormal findings	☐ N30.01	Acute cystitis with hematuria
☐ Z01.419	GYN exam without abnormal findings	☐ N39.0	Urinary tract infection, site not specified
☐ Z12.4	Screening for malignant neoplasm of cervix	☐ R30.0	Dysuria
☐ Z11.3	Screening for infections with a predominantly sexual mode of transmission	☐ R31.0	Gross hematuria
		☐ R35.0	Frequency of micturition
☐ Z11.51	Screening for HPV	☐ R39.15	Urgency of urination
☐ R97.610	ASC-US on cervical cancer	☐ R82.90	Unspecified abnormal findings in urine
☐ N76.0	Acute Vaginitis	☐ Z87.440	Personal history of UTI
☐ R87.810	Cervical High Rish HPV	☐ N76.0	Acute Vaginitis
☐ R87.612	LGSIL	☐ R30.0 + R82.71	Dysuria + Bacteriuria (Infection not confirmed but symptoms justify testing)

TEST PANEL SELECTION

A. Cytopathology & HPV Testing

- ☐ ThinPrep Pap Test
- ☐ ThinPrep Pap Test + HPV
- ☐ ThinPrep Pap; reflex to HPV for ASCUS/LSIL

B. Tissue Pathology

Site 1 _____

Site 2 _____

Site 3 _____

Site 4 _____

C. Sexual Health Profile ***(Use Aptima multi-test swab)***

- ☐ **Bacterial Vaginosis**
  Lactobacillus spp.
  L. gaseri
  L. crispatus
  L. jensenii
  Gardnerella vaginalis
  Atopobium vaginae
- ☐ **Candida Vaginitis**
  Candida albicans
  Candida glabrata
  Candida parapsilosis
  Candida tropicalis
- ☐ **HSV Panel**
  HSV 1 & HSV 2
- ☐ **CT/NG Panel**
  Chlamydia trachomatis
  Neisseria gonorrhoeae
- ☐ **CT/NG/TV Panel**
  Chlamydia trachomatis
  Neisseria gonorrhoeae
  Trichomonas vaginalis

Individual Organism

- ☐ *Mycoplasma genitalium*
- ☐ *Trichomonas vaginalis*
- ☐ HPV
- ☐ Other: _____

D. Urinary Tract Infection*

- ☐ Complete Panel
- ☐ Panel without STI

UTI Complete Panel List ***(See reverse for Antibiotic Resistance Gene Correlation)***

BACTERIA

Acinetobacter baumannii
Citrobacter freundii
Enterobacter aerogenes
Enterobacter cloacae
Enterococcus faecalis
Enterococcus faecium
Escherichia coli
Klebsiella oxytoca
Klebsiella pneumoniae
Morganella morganii
Mycoplasma genitalium
Proteus mirabilis
Proteus vulgaris
Pseudomonas aeruginosa
Providencia stuartii
Staphylococcus aureus
Staphylococcus saprophyticus
Staphylococcus agalactiae
Staphylococcus pyogenes
Ureaplasma urealyticum
Ureaplasma parvum

STI

Chlamydia trachomatis
Neisseria gonorrhoeae
Trichomonas vaginalis

YEAST

Candida albicans
Candida glabrata

BOTH PATIENT AND PHYSICIAN MUST SIGN TO APPROVE TESTING

By signing below, I confirm I have read the ABN on the reverse side.

Patient Signature: _____

I authorize the release of medical information related to services provided herein to my health plan/ insurance carrier and authorize payment directly to LabGenomics and/or lab services provider. I assume responsibility for payment of charges not covered by my healthcare insurer.

Physician Signature: _____

CMS requires physician signature on all requisitions. LabGenomics is responsible for verifying signature prior to performing testing.

Ethnicity requires only for Genetic Carrier Screening tests. Many states have enhanced legislation requiring patient consent, genetic counseling or other restrictions for ordering, performing or disclosing the results of a genetic test. Any physician ordering a genetic test must sign here acknowledging that they understand the requirements under the law of the state where the patient resides and has obtained patient consent and/or taken such other steps as the law requires including without limitation, genetic counseling: * Testing may be performed at LabGenomics Services.

300 Columbus Circle, Suite A, Edison, NJ 08837 | Tel: (866) 909-PATH | Fax: (908) 272-1478 | www.labgusa.com

T128353 **Site** _____ **Name** _____ T128353 **Site** _____ **Name** _____ T128353 **Site** _____ **Name** _____ T128353 **Site** _____ **Name** _____ T128353 **Site** _____ **Name** _____

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Antibiotic Resistance Gene Correlation

Gene Detected	Class of Antibiotics	Example of Antibiotics
AmpC	Cephalosporins	Cephalexin, cefdinir, cefazolin, cefixime,ceftriaxone, cefoxitin
blaOXA-48, KPC	Carbapenems	Meropenem, ertapenem, imipinem
ermA, ermB, ermC	Macrolides & lincosamide	Erythromycin, azithromycin, clindamycin
mecA	Methicilin	Methicillin, oxacillin, cephalexin, cefazolin
QnrA, QnrS	Fluoroquinolones	Levofloxacin, ciprofloxacin, delafloxacin, moxifloxacin
vanA, vanB, vanC	Glycopeptide	Vancomycin
SULL, DFRA	Sulfamethoxazole/trimethoprim	Bactrim
tetM	Tetracycline	Minocycline, doxycycline

Notifier(s):

Patient Name: **Identification Number:**

Advance Beneficiary Notice of Non coverage (ABN)

NOTE: If Medicare doesn't pay for items checked or listed in the box below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the items listed or checked in the box below.

Laboratory Tests	Reason Medicare May Not Pay	Estimated Costs
	Medicare may not cover this test if it is not considered medically necessary for your condition.	

What you need to do now:

- Read this notice, so you can make an informed decision about your care
- Ask us any questions that you may have after you finish reading
- Choose an option below about whether to receive the checked items listed in the first box above

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

Options: Check only one box. We cannot choose a box for you.

☐ **OPTION 1**: I want the Laboratory Test(s) listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2:** I want the Laboratory Test(s) listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3:** I do not want the Laboratory Test(s) listed above, I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

Additional information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).
Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.